
Manual for Mental Health Coverage to Uninsured Tennesseans

January 1, 2006

*Tennessee Department of Mental Health & Developmental Disabilities
Office of Managed Care
425 5th Avenue North
Cordell Hull Building, 5^h Floor
Nashville, TN 37243*

Table of Contents

Introduction	3
Definitions	4
Eligibility Criteria	8
Enrollment	10
Reverification	13
Disenrollment	14
Covered Services	15
Providers	16
Appeals	17

Manual Appendices:

Appendix I	19
Enrollment Procedures for State Only Admissions Flowchart	20
Enrollment Procedures for Judicial Admissions Flowchart	22
Appendix II	23
State Only Enrollment Request Form	24
Certificate of Diagnosis (CMHA Version)	25
CRG Assessment Form	26
TPG Assessment Form	29
TennCare Partners Program Eligibility Enrollment Request	31
Certificate of Diagnosis (RMHI Version)	32
JCCO Attestation for State Only Enrollment	33
State Only Income and Homeless Declaration Form	34
TDMHDD State Only Eligibility Review Information Gathering Letter	35
State Only Proof Attendance Form	37
State Only Appeal Request Form (Intake Version)	38
State Only Appeal Request Form (Review Version)	39
Appendix III	39
Policy and Enrollment Procedures for State Only	40
Appendix IV	45
Enrollment Procedures for Judicial Admissions	46
Appendix V	48
Policy and Procedure for Appeals of State Only Enrollment	49

Introduction

The Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) offers coverage for uninsured service recipients meeting predetermined criteria. This coverage allows for the provision of behavioral health services for those service recipients without current TennCare coverage, private health insurance, or Medicare that present at community mental health agencies, state hospitals, or other State-approved facilities. The two categories for coverage are State Only and Judicial. State Only coverage is for service recipients presenting for services at either inpatient or outpatient facilities that are considered part of the priority population, Severely and/or Persistently Mentally Ill adults and Seriously Emotionally Disturbed children. Judicial coverage is for service recipients who do not qualify for State Only coverage and who require involuntary inpatient and outpatient services.

State Only and Judicial coverage categories were started in July 2002, and the services rendered to these service recipients are paid for by state funds. There is no federal financial participation for persons who receive services through these types of coverage and the ability of TDMHDD to cover services is dependent on annual appropriations by the legislature. Therefore, it is important that service recipients covered for services through State Only or Judicial enrollment who have not applied for TennCare do so as soon as possible. This will allow more service recipients throughout the year to access State Only and Judicial coverage, as it is necessary for them to access behavioral health services.

Definitions

BHO (Behavioral Health Organization) – Type of managed care contractor approved by the Tennessee Department of Finance and Administration to deliver mental health and substance abuse services to service recipients eligible for State Only and Judicial coverage.

CRG (Clinically Related Group) – Defining and classifying consumers 18 years or older into clinically related groups involves diagnosis, the severity of functional impairment, the duration of severe functional impairment, and the need for services to prevent relapse. Based on these criteria, there are five clinically related groups:

- Group 1 - Persons with Severe and Persistent Mental Illness (SPMI)
- Group 2 - Persons with Severe Mental Illness (SMI)
- Group 3 - Persons who were Formerly Severely Impaired and need services to prevent relapse
- Group 4 - Persons with Mild or Moderate Mental Disorder
- Group 5 - Persons who are not in Clinically Related Groups 1 – 4 as a result of their diagnosis being substance use disorder, developmental disorder, or V-codes

Eligible – A service recipient who has been determined to meet the eligibility criteria for State Only or Judicial coverage.

Family - A social unit comprised of varying numbers of related individuals, either by blood or by law, who live together in the same dwelling.

Federal Poverty Level (FPL) – A type of the federal poverty measure used for administrative purposes, such as determining financial eligibility for services. Current levels can be located at <http://aspe.hhs.gov/poverty/05poverty.shtml>.

Income – The definition of income in Rule 1240-1-4 of the Tennessee Department of Human Services – Family Assistance Division.

Inmate – An individual confined in a local, state, or federal prison, jail, youth development center, or other penal or correctional facility, or on furlough from such facility.

Judicial – A coverage category for uninsured service recipients in the State of Tennessee who require involuntary psychiatric inpatient and outpatient services through a Regional Mental Health Institute (state operated hospital), TDMHDD approved private inpatient facility or outpatient treatment provider. Predetermined eligibility criteria must be met for service recipients to qualify for this coverage.

Medically Necessary – Services or supplies provided by an institution, physician, or other health care provider that are required to identify or treat an eligible service recipient's illness or injury and which are:

- (a) Consistent with the symptoms or diagnosis and treatment of the eligible service recipient's condition, disease, ailment, or injury; and
- (b) Appropriate with regard to standards or good medical practice; and
- (c) Not solely for the convenience of service recipient, physician, or other provider; and

- (d) The most appropriate supply or level of services that can safely be provided to the service recipient. When applied to the care rendered in an inpatient setting, it further means that services for the service recipient's medical symptoms or condition require that the services cannot be safely provided to the service recipient in an outpatient setting.
- (e) When applied to eligible service recipients under twenty-one (21) years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart-B, and the Omnibus Budget Reconciliation Act of 1989.

Non-Priority Service Recipients – Individuals seeking behavioral health services in the State of Tennessee who are deemed not Severely and/or Persistently Mentally Ill by having a Clinically Related Group rating of Group 4 or Group 5 for persons 18 years and older or are deemed not Seriously Emotionally Disturbed by having a Target Population Group rating of Group 3 or Group 4 for persons under 18 years of age.

Priority Service Recipients – Individuals seeking behavioral health services in the State of Tennessee who are deemed Severely and/or Persistently Mentally Ill by having a Clinically Related Group rating of Group 1, 2 or 3 for persons 18 years and older or are deemed Seriously Emotionally Disturbed by having a Target Population Group rating of Group 2 for persons under 18 years of age.

Provider – A TDMHDD-approved institution, facility, agency, person, corporation, partnership, or association which accepts payment for providing services to a service recipient with State Only or Judicial coverage.

Seriously Emotionally Disturbed (SED) - Persons who have been identified by the Tennessee Department of Mental Health and Developmental Disabilities or its designee as meeting the criteria provided below:

- (a) Person under the age of 18, and
- (b) Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association with the exception of DSM-IV-TR (and subsequent revisions) V- codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable mental, behavioral, or emotional disturbance other than above exclusions. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects; and
- (c) The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and is evidenced by a Global Assessment of Functioning (GAF) score of 50 or less in accordance with the DSM-IV-TR (and subsequent revisions). Children and adolescents who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

Severely and/or Persistently Mentally Ill (SPMI/SMI) - Service recipients who have been identified by the

Tennessee Department of Mental Health and Developmental Disabilities or its designee as meeting the following criteria. These persons will be identified as belonging in one of the clinically related groups that follow the criteria:

- (a) Age 18 and over; and
- (b) Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association, with the exception of DSM-IV-TR (and subsequent revisions) V-codes, substance use disorders, and developmental disorders, unless these disorders co-occur with another diagnosable serious mental illness other than above exclusions. All of these disorders have episodic, recurrent, or persistent features, however, they vary in terms of severity and disabling effects; and
- (c) The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment that substantially interferes with or limits major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in major life activities including basic living skills (e.g., eating, bathing, dressing); instrumental living skills (maintaining a household, managing money, getting around in the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. This definition includes adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services.

State Only – A coverage category for uninsured service recipients who are classified in the priority population in the State of Tennessee and require behavioral health services on an inpatient or outpatient basis. Predetermined eligibility criteria must be met for service recipients to qualify for this coverage.

Target Population Group (TPG) - An assessment mechanism for children and adolescents under the age of 18 to determine an service recipient's level of functioning and severity of impairment due to a mental illness. Based on these criteria, there are three target population groups:

- (a) Target Population Group 2: Seriously Emotionally Disturbed (SED)
Children and adolescents under 18 years of age with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children are currently severely impaired as evidenced by 50 or less Global Assessment of Functioning (GAF).
- (b) Target Population Group 3: At Risk of a (SED)
Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children may or may not be currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have psychosocial issues that can potentially place them at risk of a SED.
- (c) Target Population Group 4: Persons who do not meet criteria TPG Group 2 or 3
Children and adolescents under 18 years of age without a valid DSM-IV-TR (and subsequent

revisions) diagnosis and are not currently seriously impaired as evidenced by Global Assessment of Functioning (GAF). These children have no psychosocial issues that can potentially place them at risk of a SED.

TennCare – The program administered by the Single State Agency as designated by the State and the Centers for Medicare and Medicaid Services pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration waiver granted to the State of Tennessee.

Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) – The State agency responsible for the provision of services to service recipients deemed eligible for State Only and Judicial coverage.

Eligibility Criteria

The Tennessee Department of Mental Health and Developmental Disabilities shall be the lead State Agency responsible for determining eligibility and contracting for services to be rendered to service recipients who qualify for State Only and Judicial coverage. Behavioral health organizations may be contracted by TDMHDD to deliver covered mental health and substance abuse services and a Pharmacy Benefits Manager may be utilized for the rendering of pharmacy benefits to service recipients who qualify for State Only and Judicial enrollment. TDMHDD may also contract directly with providers to render services. There are technical and financial eligibility requirements that must be met by service recipients before they can qualify for State Only and Judicial coverage.

By applying for State Only coverage, the service recipient grants permission and authorizes release of information to TDMHDD, or its designee, to investigate any and all information provided, or any information not provided if it could affect eligibility, to determine State Only coverage eligibility. Information may be verified through, but not limited to, the following sources:

1. Federal income tax records;
2. State income tax records for Tennessee or any other state where income is earned;
3. The Tennessee Labor and Work Force Development, and other employment security offices within any state whereby the applicant may have received wages or been employed;
4. Credit bureaus;
5. Insurance companies;
6. Any other governmental agency, or public or private source of information where such information may impact a service recipient's eligibility for State Only coverage.

What are the eligibility criteria for State Only coverage?

1. Been determined ineligible for TennCare or have a pending TennCare application; and
2. Not be a prior TennCare enrollee terminated from coverage as a part of TennCare Reform with access to safety net services; and
3. Not have access to private health insurance, or the private health insurance lacks mental health coverage or all mental health benefits under private health insurance have been exhausted; and
4. Not have Medicare coverage; and
5. Not be actively receiving benefits through the Veteran's Administration; and
6. Be a U.S. Citizen or a legal resident Alien; and
7. Be a resident of Tennessee; and
8. Have been identified as SPMI/SED (CRG = 1, 2, or 3; TPG = 2); and
9. Have family income no greater than 100% of the Federal Poverty Level (FPL); and
10. Must not be an inmate.

What are the eligibility criteria for Judicial coverage?

1. Not be eligible for TennCare coverage; and
2. Not have access to private health insurance; and
3. Not have Medicare coverage, or Medicare hospital and/or doctor's days have been exhausted; and
4. Not be actively receiving benefits through the Veteran's Administration; and
5. Have been **involuntarily** committed to a psychiatric inpatient hospital or directed to receive Mandatory Outpatient Treatment (MOT) services from an outpatient provider of behavioral health services; and
6. Have been identified as being non-SPMI/SED based upon the current CRG/TPG assessment (i.e. CRG = 4 or 5; TPG = 3 or 4); or
7. Been determined to be SPMI/SED, but fail to meet other State Only enrollment criteria.

NOTE: Service recipients who were terminated from TennCare coverage as a part of TennCare Reform and with access to safety net services are considered eligible for Judicial coverage if they meet the criteria above.

Enrollment

The required paperwork for State Only and Judicial coverage depends upon whether the paperwork originates from an inpatient facility or Community Mental Health Agency (CMHA). However, in both instances the paperwork is nearly identical. The only real difference being the specific type of enrollment request form utilized in the application process; the supporting documentation is the same.

Flow charts detailing the entire process for enrollment of State Only and Judicial applicants can be found in Appendix I.

What Paperwork is Required for the State Only Application?

If a person is admitted to an inpatient facility and its staff determines that the person is a potential candidate for State Only coverage, the inpatient staff will submit the following paperwork:

1. TennCare Partners Program Eligibility Enrollment Request with Section I and Section III completed;
2. Certificate of Diagnosis;
3. Copy of the TennCare (DHS) application or DHS Notice of Disposition;
4. Copy of the CRG/TPG assessment, as appropriate;
5. Proof of current visa or green card if the service recipient is a legal resident Alien;
6. Current family income information; and
7. Proof of current residency in the State of Tennessee.

If a person presents for mental health services at a CMHA and the CMHA staff determines that the person is a potential candidate of State Only coverage, the CMHA staff will submit the following paperwork:

1. TennCare Partners Program “State Only” Enrollment Request;
2. Certificate of Diagnosis;
3. Copy of the TennCare application, if available;
4. Copy of the CRG/TPG assessment, as appropriate;
5. Proof of current visa or green card if the service recipient is a legal resident Alien;
6. Current family income information; and
7. Proof of current residency in the State of Tennessee.

Copies of the various forms used in the State Only enrollment process are located in Appendix II and TDMHDD’s policy and enrollment procedures for this coverage category can be found in Appendix III.

What Paperwork is Required for the Judicial Application?

If a person without current TennCare coverage, private health insurance, or Medicare is involuntarily committed for treatment and evaluation to a RMHI or one of the approved psychiatric hospitals, the hospital staff will submit the following paperwork:

1. TennCare Partners Program Eligibility Enrollment Request with Section II and Section III completed
2. Copy of the court order or copies of the two Certificates of Need

Copies of the various forms used in the Judicial enrollment process are located in Appendix II and TDMHDD's policy and enrollment procedures for this coverage category can be found in Appendix IV.

Where Do I Send the Completed State Only and/or Judicial Application?

Both State Only and Judicial enrollment request packets are submitted to the same unit for processing. The enrollment request packets are sent to the Eligibility Unit within the Office of Managed Care, a division of the Tennessee Department of Mental Health and Developmental Disabilities. State Only and Judicial enrollment request packets may be submitted to the Eligibility Unit via the U.S. Postal Service or via fax.

The Eligibility Unit's mailing address is as follows.

**Tennessee Department of Mental Health and Developmental Disabilities
Office of Managed Care, Eligibility Unit
5th Floor, Cordell Hull Building
425 5th Ave North
Nashville TN 37243**

The Eligibility Unit's fax number is **(615) 253 – 3187**.

What Happens Once an Application is Received by TDMHDD?

Once the Eligibility Unit receives a State Only or Judicial enrollment request packet, an electronic record of the information on the enrollment request is created. Then, the enrollment packet will be screened for completeness. If the packet is complete, the service recipient will be screened for potential eligibility, based upon the information contained within the enrollment request packet. If the service recipient is eligible, an approval code is entered on the electronic record.

What Happens Once an Application is Approved?

After the record is approved, the Information Systems division of TDMHDD will create a file containing the approval records for a given day. This file is then uploaded to the state main frame computer, where it will be picked up by the Information Systems division of the TennCare Bureau. This process on average takes from two (2) to four (4) business days to complete. After the TDMHDD electronically transmits to the TennCare Bureau the file containing the State Only and Judicial approvals, it will be placed into the Bureau's next batch processing run. The TennCare Bureau will process and load the BHO coverage based upon the State Only and Judicial

approval. This process takes one (1) to three (3) business days. Therefore, the entire process usually takes from three (3) to seven (7) calendar days to complete.

What is Considered the Effective Date of Enrollment?

For State Only applicants, the effective date of enrollment depends upon the timely receipt of an appropriately completed applications from providers when the applications evidence that all of the eligibility criteria is met. If a completed application is received within thirty (30) calendar days from the initial service date, the initial service date will be the effective date of enrollment. If a completed application is received more than thirty (30) calendar days from the initial date of service, the effective date of enrollment will be the date the completed application is received by TDMHDD's Eligibility Unit. It is important to note that if an incomplete application is received within thirty (30) calendar days from initial date of service and is not rectified within this time period, the effective date of enrollment will be the date the completed application is received. Therefore, it is in the service recipients' and providers' best interest to submit applications as soon as possible after individuals present for services.

For Judicial applicants, the date of commitment to services for evaluation and treatment as evidenced by the execution date of the court order or the most recent date on the two certificates of need.

How Will I Know if a Service Recipient has been Approved?

Each week, usually on Mondays, a report is emailed to a designated contact within each inpatient facility and CMHA. This report is entitled the Confirmation List, and it is sent in the form of a password protected Word file. This report contains the following information:

1. The enrollee's name, date of birth, and Social Security number
2. Their BHO assignment
3. Date the State Only or Judicial enrollment request was received by the Eligibility Unit
4. Date the enrollee's electronic record was transmitted to the TennCare Bureau
5. Start date of the BHO coverage; and
6. Information on the active status of BHO coverage in the TennCare database.

Reverification

The Tennessee Department of Mental Health and Developmental Disabilities shall be responsible for the reverification of State Only and Judicial coverage. This reverification process shall be completed at a minimum of every three (3) months for State Only enrollees and monthly for Judicial enrollees. The primary purpose of reverification is to ensure that those who continue to access behavioral health services through these coverage categories still meet the criteria for eligibility.

What documentation may be required to reverify State Only coverage?

1. Completed and signed State Only Eligibility Review form;
2. Proof of appointment with DHS having occurred with status of the application to TennCare, if the service recipient has a pending application;
3. Proof of current visa or green card if the service recipient is a legal resident Alien;
4. Proof of participation in substance abuse treatment, if the service recipient is dually diagnosed with mental health and substance abuse disorders;
5. Current family income information; and
6. Proof of current residency in the State of Tennessee.

What documentation may be required to reverify Judicial coverage?

1. Current court order for proof of continued mandatory outpatient treatment or involuntary commitment if the service recipient was admitted with two certificates of need or a time limited court order; and
2. Verification from the provider that the service recipient continues to receive services through an involuntary commitment status or mandatory outpatient treatment; and
3. Verification that the service recipient continues to not meet eligibility criteria for TennCare and State Only coverage.

NOTE: Additional documentation may be required depending on the particulars of a given case.

Disenrollment

Through the reverification process, TDMHDD will determine if service recipients still meet the criteria to continue their coverage as a State Only or Judicial enrollee. When service recipients are determined to no longer meet the criteria to continue coverage, they will be notified in writing of the termination of coverage and the date that this termination will become effective.

When will a Service Recipient be Disenrolled from State Only Coverage?

1. The service recipient no longer meets State Only eligibility criteria; or
2. The service recipient who is dually diagnosed with mental health and substance abuse disorders fails to provide documentation of ongoing participation in a substance abuse program; or
3. The service recipient with a pending TennCare application fails to provide documentation of DHS appointment that is either scheduled or has occurred.

When will a Service Recipient be Disenrolled from Judicial Coverage?

1. The service recipient no longer meets Judicial eligibility criteria; or
2. The service recipient is determined eligible for TennCare coverage, private insurance, or Medicare; or
3. The service recipient is determined to meet criteria for State Only coverage.

Covered Services

What Services Can a Service Recipient with State Only Coverage Access?

Covered services for service recipients **21 years of age and older** enrolled as State Only include:

1. Psychiatric inpatient hospital services (including physician services);
2. Outpatient mental health services (including physician services);
3. Inpatient/residential & outpatient substance abuse services (limited to 10 days detoxification and \$30,000 in medically necessary lifetime benefits);
4. 24-Hour psychiatric residential treatment;
5. Mental health case management;
6. Non-emergency transportation;
7. Emergency air & ground ambulance services;
8. Psychiatric rehabilitation services;
9. Psychiatric medications (limited to 5 prescriptions a month with only 2 brand names); and
10. Lab related to medication management.

Covered services for service recipients **under 21 years of age** enrolled as State Only include:

1. Psychiatric inpatient hospital services (including physician services);
2. Outpatient mental health services (including physician services);
3. Inpatient/residential and outpatient substance abuse services;
4. 24-Hour psychiatric residential treatment;
5. Mental health case management;
6. Non-emergency transportation;
7. Emergency air & ground ambulance services;
8. Psychiatric medication management;
9. Psychiatric medications; and
10. Lab related to medication management.

What Services Can a Service Recipient with Judicial Coverage Access?

Covered services for service recipients designated as meeting the Judicial eligibility criteria are limited to only involuntary psychiatric hospitalizations and court ordered mandatory outpatient treatment services covered by the TennCare Partners Program.

Providers

Providers must be authorized and trained by the Tennessee Department of Mental Health and Developmental Disabilities before they may be a provider rendering services to State Only and Judicial enrollees. These providers must have the ability to complete the Clinically Related Group and Target Population Group assessments that determine priority status. They must also meet the following criteria:

1. Maintain Tennessee medical licenses and/or certifications as required by his/her practice, or licensure by TDMHDD, if appropriate;
2. Are not under a federal Drug Enforcement Agency (DEA) restriction of his/her prescribing and/or dispensing certification for scheduled drugs;
3. Agree to maintain and provide access to TDMHDD and/or its agent all medical records for State Only and Judicial enrollees for five (5) years from the date of service or, in the case of service recipients under 18 years, until the child/adolescent reaches 23 years of age; and
4. Provide medical assistance at or above recognized standards of practice.

How Does a Provider File a Claim for Reimbursement?

Currently, approval for services administered through the BHO for State Only and Judicial enrollees is essentially the same as approval for services for enrollees in TennCare. In other words, while the eligibility file provided by the TennCare Bureau to the BHO does indicate which service recipients are approved for State Only or Judicial coverage, no distinction is made in the BHO reimbursement process. Therefore, providers are able to file claims for reimbursement on State Only and Judicial enrollees in the same manner that reimbursement claims are filed on patients with full TennCare coverage.

Payment arrangements between the behavioral health organizations and providers may differ from TennCare enrollees given potential reductions in services covered for the State Only and Judicial service recipients. Providers, however, may seek payment from service recipients whose eligibility for State Only or Judicial coverage is pending at the time services are rendered. Providers may bill such service recipients at the provider's usual and customary rate for the rendered services.

Appeals

Can a Service Recipient Appeal if they are Deemed Ineligible for State Only Coverage?

Yes, any service recipient determined ineligible for State Only coverage will receive an initial denial notice or a notice of termination from coverage. Whether this notice occurs as an initial denial or a denial during the reverification process, it will include a separate State Only appeal form. The appeal form will give denied or closed State Only service recipients the opportunity to contest the reason(s) for denial or closure. Documentation to verify the service recipient's contention of the reason for denial or closure **must** accompany the appeal form.

What Does a Service Recipient Need to do to Appeal if they are Deemed Ineligible for State Only Coverage?

When a service recipient receives an initial denial notice or a notice of termination from coverage, it will include the following:

1. Information on how to appeal if the service recipient believes the determination to terminate coverage is based on erroneous information;
2. A deadline for submission of the completed appeal form and all required documentation for the termination decision to receive reconsideration;
3. A list of all required documentation and the appeal form necessary for submission of the appeal for reconsideration; and
4. Directions on where to mail the form and all required documentation.

Appeal forms should be sent to:

**TDMHDD
OFFICE OF CONSUMER AFFAIRS
ATTN: ELIGIBILITY APPEALS
P.O. BOX 332548
Nashville, TN 37203**

Full details of the appeal process can be found in Appendix V.

Service recipients who submit appeal forms that are incomplete and/or do not submit all of the required documentation as outlined in the notice of termination by the deadline in the notice shall be terminated for coverage of services. Complete and timely submissions of appeals for continuation of coverage shall be completed within thirty (30) calendar days and written response shall be sent to the service recipients requesting the appeals and their providers. Coverage of services may continue without interruption until the appeal is resolved if the service recipient has State Only coverage. Termination of coverage shall not exclude service recipients from reapplying at a later date for State Only and/or Judicial coverage.

Can a Service Recipient Appeal if they are Deemed Ineligible for Judicial Coverage?

If a service recipient is admitted for involuntary evaluation and treatment under a court order or two Certificates of Need, then the service recipient becomes eligible for Judicial coverage. The court order and the two Certificates of Need carry the weight of law and the Judicial coverage must be granted if there is no other mechanism in place to pay for the service. Under these circumstances a denial of coverage is not possible and there is no need for appeal procedures for coverage eligibility.

Can a Service Recipient Appeal for the Denial, Delay, Reduction, Suspension or Termination of Services?

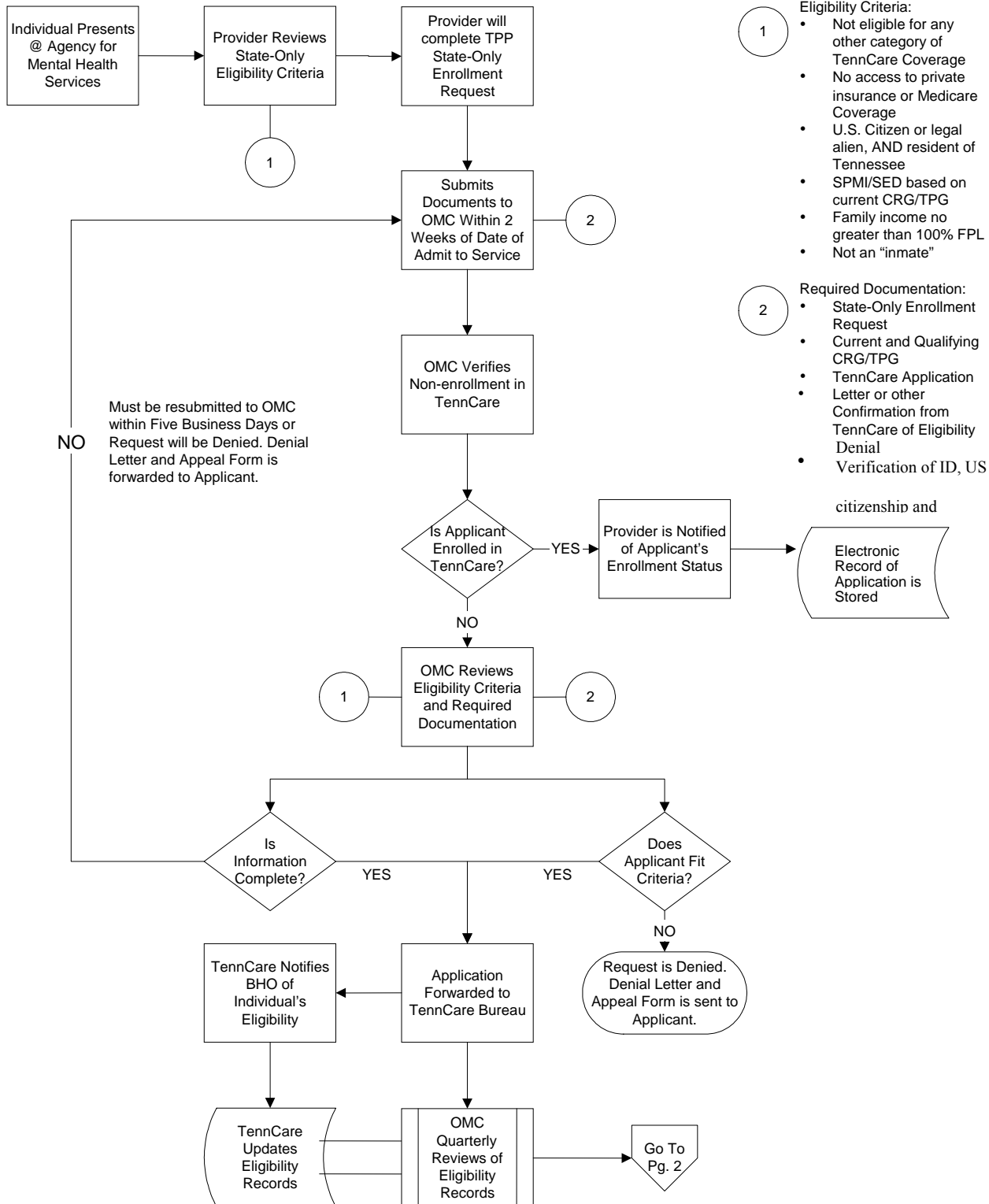
Service recipients who receive services under the State Only or Judicial coverage categories do not have the same rights to appeal as TennCare enrollees. Since no federal financial participation is received for service recipients in these eligibility categories and they are not covered under Title XIX, the Revised Grier Consent Decree (Modified) does not apply. Service appeals should not be directed to the TennCare Solutions Unit, which handles appeals for TennCare enrollees, as they will be informally closed by forwarding them to TDMHDD for resolution. Service appeals sent to the attention of the TDMHDD Office of Consumer Affairs will be returned to the State Only or Judicial enrollee with explanation that there is no process to appeal for services given these coverage categories. The behavioral health organizations can apply medical necessity criteria for the prior and continued authorization of services to be rendered to State Only and Judicial service recipients.

Can a Service Recipient Appeal for Reimbursement of Services Already Rendered?

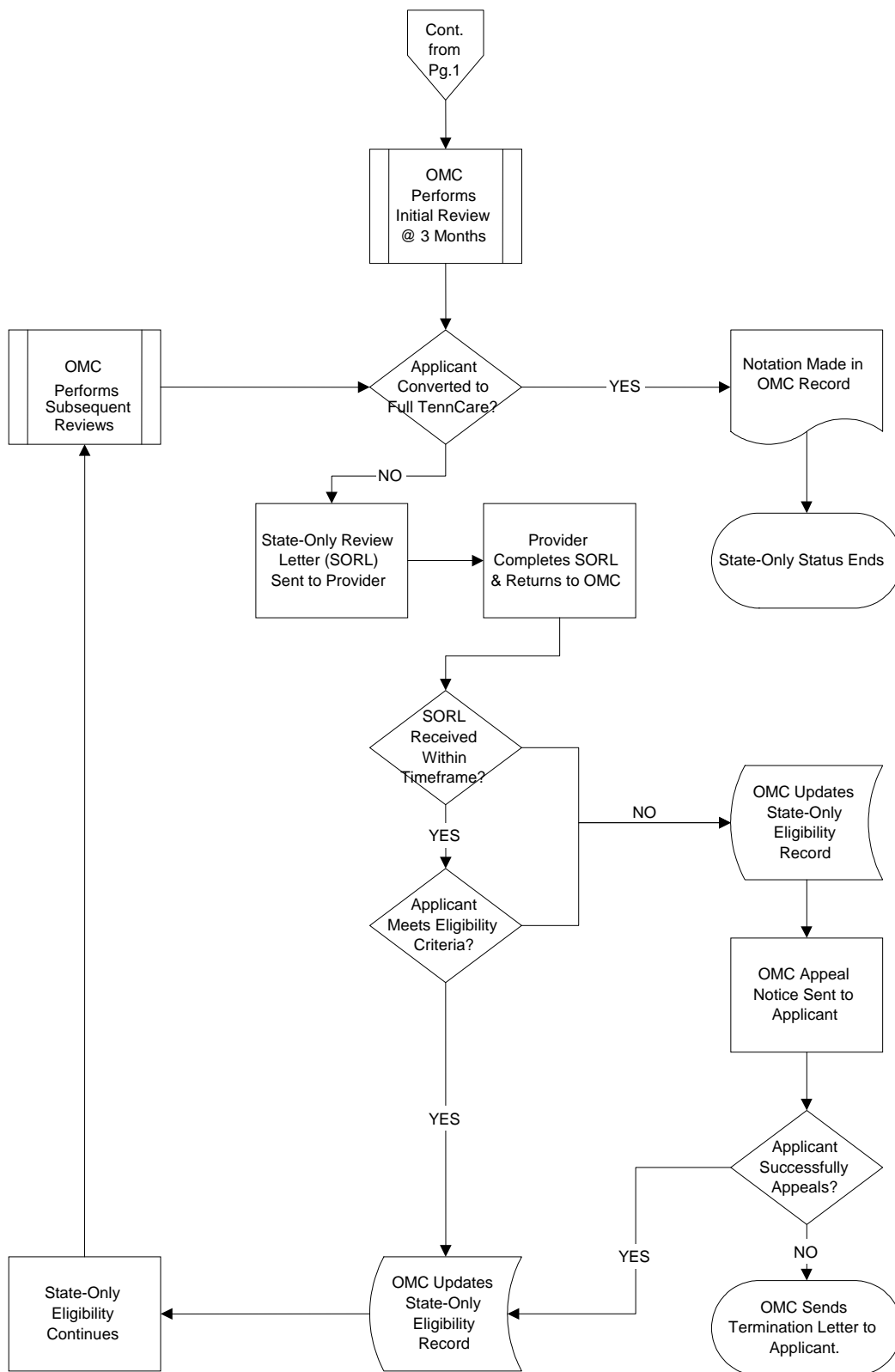
If a provider is delayed in submitting a complete application for State Only or Judicial coverage and rectifies this within thirty (30) calendar days of the initial date of services for which reimbursement is being sought, the application can be processed with coverage going back to the initial service date. This will depend on whether other required documentation was completed at the time the initial service was rendered. After thirty (30) calendar days, the application will be processed with an effective date given as the date the completed application was received by the Eligibility Unit. Reimbursement for services rendered is contingent on coverage at the time the service(s) was rendered and appeals will not be processed unless it is the denial or termination of coverage detailed above that is being contested.

Appendix I:
State Only & Judicial
Enrollment Procedures
Flowcharts

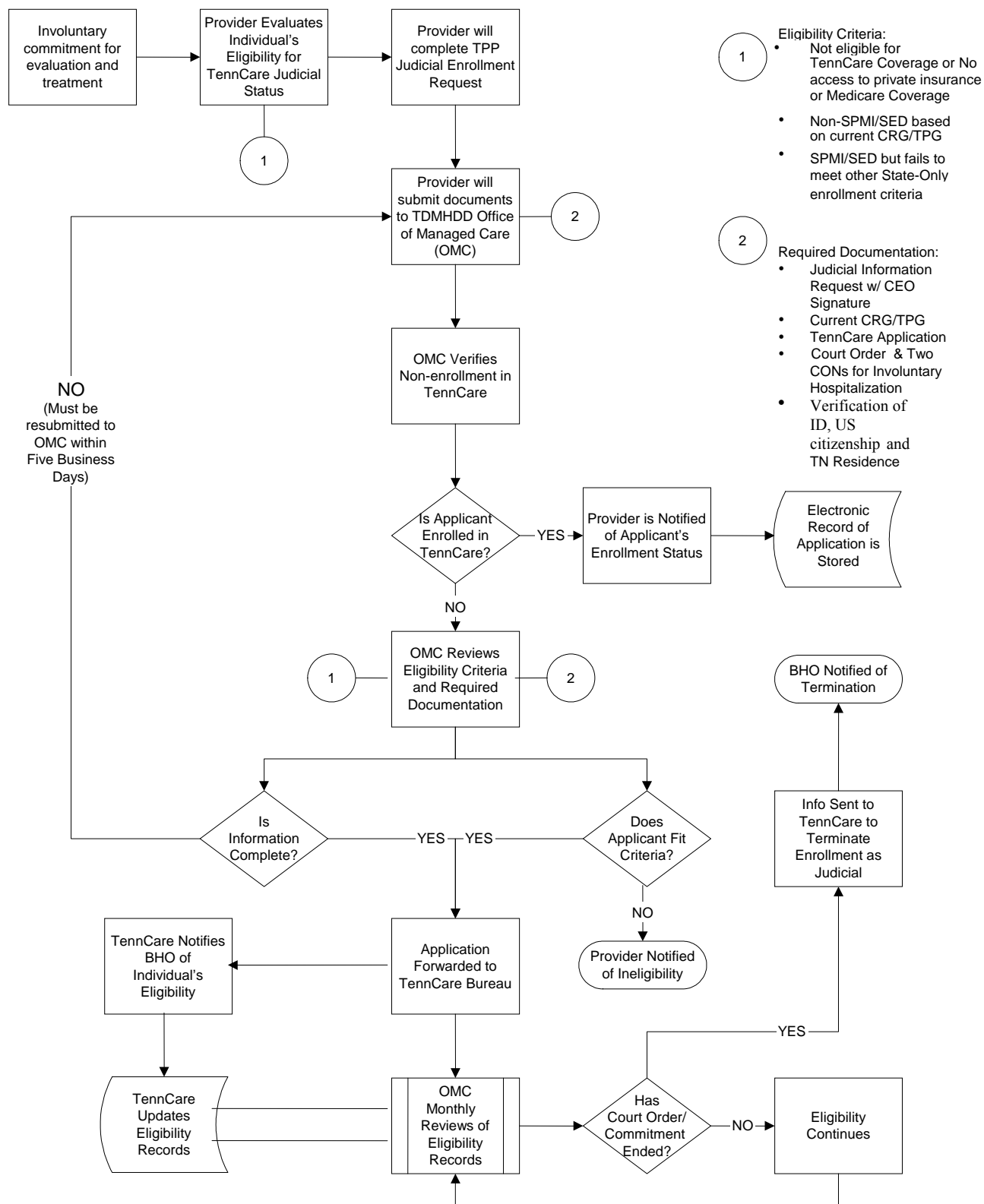
Enrollment Procedures for State-Only Category



Enrollment Procedures for State-Only Category (continued)



Enrollment Procedures for Judicial Admissions



Appendix II: State Only & Judicial Enrollment Forms

TENNCARE PARTNERS PROGRAM
"STATE ONLY" ENROLLMENT REQUEST

Patient Name: _____
(Please Print Clearly) First Name MI Last Name

Address: _____ Race: _____

City: _____ TN _____ Sex: _____
Zip Code

SSN: _____ / _____ / _____ County Code: _____
Social Security Number Date of Birth

Service Recipient Signature: _____

Date of Admission to Service: ____/____/____

- **Referred to:** _____ CMHA for outpatient services.

The service recipient identified above qualifies for the TennCare Partners Program as a "State Only". I certify that the service recipient meets the following criteria:

- The service recipient has a current CRG assessment of CRG1, CRG2, CRG3, OR A TPG2. CRG/TPG Assessment is _____. Date of latest Assessment is _____.
- The service recipient's Gross Monthly Income is \$_____ and does not exceed the Federal Poverty Guidelines below:

<u>Number in</u> <u>Family</u>	<u>Monthly</u> <u>Income</u>	<u>Number in</u> <u>Family</u>	<u>Monthly</u> <u>Income</u>
1	798	6	2156
2	1069	7	2428
3	1341	8	2699
4	1613	9	2971
5	1884	10	3243

Please **circle number in household**. For each family member over 10, add \$272 per month.

- The service recipient has made application for TennCare or has made application for TennCare and has been denied.

The following documents must be attached in support:

- **Copy of original TennCare application, if available**
- **Copy of letter, or other TennCare confirmation of denial of application for TennCare benefits, if available**
- **Copy of CRG/TPG Assessment**
- **Certificate of Diagnosis signed by a licensed mental health professional**
- **Verification of U.S. citizenship, Tennessee residence, and income**

PROVIDER Name: _____

Signature of
CHIEF EXECUTIVE OFFICER

Date

Mail to: Tennessee Department of Mental Health and Developmental Disabilities
Office of Managed Care, Eligibility Unit
5TH Floor, Cordell Hull Building
425 5th Avenue North
Nashville, TN 37243

Revised: 10/27/2005



Certificate of Diagnosis

Patient Name:			
First Name	MI	Last Name	
Social Security Number: - - Date of Birth: / / -			

Agency Contact Information

Facility Name: _____

Address: _____
Street Address City State Zip

Office Phone Number: _____ **Fax:** _____

Was a CRG/TPG assessment conducted for the person whose name is on this form? ☐ Yes ☐ No

I certify that the above-named patient has been diagnosed with the following mental health or emotional conditions:

_____	_____
_____	_____

I certify that a CRG/TPG assessment was performed on the above named individual. I understand that this information will be used to determine this patient's medical eligibility for State Only or TennCare Standard. I understand any intentional act on my part to provide false information that will potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the State's TennCare program and Title XIX of the Social Security Act.

Date: ____ / ____ / ____ Tennessee License Number: _____

Professional Designation: _____

Licensed Mental Health Professional Signature: _____

MH-5251

Revised: 06/09/04

THE TENNESSEE CLINICALLY RELATED GROUP (CRG) FORM FOR ADULTS AGE 18 AND ABOVE

IDENTIFYING INFORMATION

1. CHECK BOX THAT APPLIES:	CRG ASSESSMENT - INITIAL <input type="checkbox"/>	CRG ASSESSMENT - CORRECTION <input type="checkbox"/>	CRG ASSESSMENT - UPDATE <input type="checkbox"/>
2. BHO ID NUMBER (IF KNOWN)	<input type="text"/> <input type="text"/> <input type="text"/>	3. CONSUMER'S SSN:	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4. CONSUMER'S FIRST NAME:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	5. CONSUMER'S MIDDLE INITIAL:	<input type="text"/>
6. CONSUMER'S LAST NAME:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
7. CONSUMER'S DOB:	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
8. PRINCIPAL DIAGNOSIS:	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>		
	9. DUAL PRINCIPAL / SECONDARY DIAGNOSIS: <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>		

FUNCTIONAL ASSESSMENT

Focus on the consumer's **LOWEST** level of functioning during the past one year and use the following functional impairment scales to describe the level of impairment due to mental illness. Enter the appropriate number in the corresponding box to the right. (See "Additional Guidelines for Assessing Level of Functioning" for the expanded criteria for each scale, if necessary.)

10. ACTIVITIES OF DAILY LIVING: Include activities such as cleaning; shopping; taking public transportation; paying bills; maintaining a residence; grooming and hygiene; using telephones and directories; using a post office; etc. Also taken into account is the individual's independence, appropriateness, and effectiveness in executing these skills, as well as the ability to initiate and participate in such activities without supervision or direction. <input type="checkbox"/>				
EXTREME (1) Unable to perform any daily routine activities and requires constant assistance in most areas. Extreme dysfunction in this area may cause marked dysfunction in other areas. _____ _____	MARKED (2) Has extensive problems with performing daily routine activities and requires frequent assistance. _____ _____	MODERATE (3) Has regular or frequent problems with performing daily routine activities and is unable to perform up to acceptable standards without frequent assistance. _____ _____	MILD (4) Has some or occasional problems with performing daily routine activities and could benefit from some assistance. _____ _____	NONE (5) Has no problem performing daily routine activities without assistance _____ _____
11. INTERPERSONAL FUNCTIONING: Capacity to interact appropriately and communicate effectively with others and get along with family and community. Deficits are reflected in history of altercations; evictions or firings; fear of strangers; avoidance of interpersonal relationships and social isolation. Strengths are reflected in ability to initiate social contact and to participate actively in groups, cooperative behavior, and consideration of and sensitivity to others' feelings. <input type="checkbox"/>				
EXTREME (1) Isolated in the community; has no support network and/or no ability to take part in social activities or self manage in relationships with others and/or demonstrates extreme aggression with inability to control behavior. _____ _____ _____	MARKED (2) Isolated in the community; uses agency staff or program for social support and/or has substantial impairment in the ability to take part in social activities or self manage in relationships with others and/or demonstrates aggressive episodes but can control behavior with assistance. _____ _____ _____	MODERATE (3) Limited integration in the community; little or no use of natural supports and/or marginal capacity to take part in a variety of social activities or manage self in relationship to others and/or demonstrates aggressive episodes with limited ability to self manage behavior. _____ _____ _____	MILD (4) Partial integration into community life; uses natural supports and/or participates in appropriate interaction with others within expected social, developmental, and cultural norms when engaged and/or demonstrates aggressive episodes with ability to self manage behavior. _____ _____ _____	NONE (5) Full integration into community life; uses natural supports and/or initiates appropriate interaction with others within expected social, developmental, and cultural norms and/or asserts self appropriately. _____ _____ _____

12. CONCENTRATION, TASK PERFORMANCE, AND PACE: Ability to sustain focused attention for long enough time to permit the completion of tasks commonly found in work settings or other structured situations in school and home. Deficits are reflected in inability to concentrate and/or complete simple tasks within required time; committing frequent errors; or requiring assistance in completing such tasks. ☐

EXTREME (1) Unable to complete simple tasks.	MARKED (2) Seldom able to concentrate and has extensive difficulty completing simple tasks without assistance.	MODERATE (3) Regular or frequent difficulty with concentration and can complete simple tasks within timeframes and/but needs prompting and help.	MILD (4) Some or occasional difficulty with the ability to concentrate and can complete simple tasks within timeframes with few errors and with some assistance.	NONE (5) Has ability to concentrate and can complete simple tasks within set timeframes with few errors and without assistance.
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

13. ADAPTATION TO CHANGE: Ability to cope with stressful circumstances associated with work, school, family, or social interaction. Deficits are reflected when any unexpected environmental change causes agitation; exacerbation of signs and symptoms associated with the illness; or withdrawal from the stressful situation. ☐

EXTREME (1) No tolerance for any changes; negative reaction may cause marked dysfunction in other areas.	MARKED (2) Extensive difficulty in adjusting to change; will require a significant amount of intervention.	MODERATE (3) Regular or frequent difficulty in accepting and adjusting to change; adaptation will require some intervention.	MILD (4) Some or occasional difficulty in accepting and adjusting to change; may need minimal support.	NONE (5) Able to reasonably adapt to change within developmental and cultural norms.
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

14. SEVERITY OF IMPAIRMENT: Referring to the above four scales (questions #10 - #13), is there MODERATE (3) impairment in all four areas OR MODERATE (3) impairment in three areas and EXTREME (1) or MARKED (2) in one area OR MARKED (2) impairment in at least two areas OR EXTREME (1) impairment in at least one area? (Check "YES" or "NO")

YES ☐ NO ☐

(GO TO #15) (GO TO #16)

15. DURATION: Answer this question only if you checked "YES" for #14.

Focus on the dysfunctional periods identified when you completed the level of functioning scales above (#10 - #13). Over the past year, did these periods of severe dysfunction accumulate to a total of six months duration or longer? (Check "YES" or "NO", skip questions #16 & #17 and go to question #18.)

YES ☐ NO ☐

(GO TO #18) (GO TO #18)

16. FORMERLY SEVERE: If the person has not recently experienced severe functional impairment, i.e. checked "NO" for #14, has the consumer experienced periods of severe impairment in the past? (Check "YES" or "NO")

YES ☐ NO ☐

(GO TO #17) (GO TO #18)

17. NEEDS SERVICES TO PREVENT RELAPSE: If you answered "YES" to #16, does the person need mental health services to prevent relapse?

Mental health services are those services provided by mental health providers and include, but are not limited to: psychiatric services, therapy, case management, psychosocial rehabilitation, etc.

YES ☐ NO ☐

(GO TO #18) (GO TO #18)

18. DETERMINATION OF CONSUMER GROUP: The description of each consumer group is given below, based on the diagnosis and on the answers to the preceding questions. Review the consumer's diagnosis. If the diagnosis(es) place the consumer in Group 5, check that box. Otherwise, following the criteria noted, check the box that represents the consumer's group.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GROUP 1 - Persons with Severe and Persistent Mental Illness: Persons in this group are recently severely impaired ("YES" on question #14) and the duration of their severe impairment totals six months or longer of the past year ("YES" on question #15).	GROUP 2 - Persons with Severe Mental Illness: Persons in this group are recently severely impaired ("YES" on question #14) and the duration of their severe impairment totals less than six months of the past year ("NO" on question #15).	GROUP 3 - Persons who are Formerly Severely Impaired: Persons in this group are not recently severely impaired ("NO" to question # 14) but have been severely impaired in the past ("YES" to question #16) and need services to prevent relapse ("YES" to question #17).	GROUP 4 - Persons with Mild or Moderate Mental Disorders: Persons in this group are not recently severely impaired ("NO" to question #14). These persons are <u>either</u> not formerly severely mentally ill ("NO" to question #16) <u>or</u> are formerly severely mentally ill ("YES" to question #16) and do not need services to prevent relapse ("NO" to question #17).	GROUP 5 - Persons who are not in clinically related groups 1-4 as a result of their diagnosis. The diagnosis(es) of consumer's in this group include only: substance use disorders (DSM-IV-TR ranges: 291.0 - 292.9, 303.00 - 305.90), developmental disorders (DSM-IV-TR ranges: 299.00 - 299.80, 315.00 - 319), or V-codes (DSM-IV-TR range: V15.81 - V71.09).

19. REASON FOR ASSESSMENT (Check One)

- | | | |
|--|---|--|
| <p>01 <input type="checkbox"/> Consumer requested CRG assessment</p> <p>03 <input type="checkbox"/> Mental health care provider requested assessment</p> <p>05 <input type="checkbox"/> TDMHDD requested CRG assessment</p> <p>07 <input type="checkbox"/> MCO requested CRG assessment</p> <p>09 <input type="checkbox"/> Consumer is referred for a mental health service in the Enhanced Benefits Package (For currently enrolled participants in the TennCare Partners Program)</p> <p>11 <input type="checkbox"/> Consumer used 15 consecutive inpatient psychiatric days in a calendar year (For currently enrolled participants in the TennCare Partners Program)</p> <p>13 <input type="checkbox"/> Consumer has been admitted to an RMHI and is potentially eligible for Federal and/or State supported benefits (For persons not currently enrolled in the TennCare Partners Program)</p> | <p>12 <input type="checkbox"/> Consumer used 30 cumulative inpatient psychiatric days in a calendar year (For currently enrolled participants in the TennCare Partners Program)</p> <p>14 <input type="checkbox"/> Other</p> <p>15 <input type="checkbox"/> Intake</p> | <p>02 <input type="checkbox"/> Family member requested CRG assessment for the consumer</p> <p>04 <input type="checkbox"/> Primary health care provider requested CRG assessment</p> <p>06 <input type="checkbox"/> BHO requested CRG assessment</p> <p>08 <input type="checkbox"/> One year reassessment is due</p> <p>10 <input type="checkbox"/> Consumer used 40 outpatient mental health benefits in a calendar year (For currently enrolled participants in the TennCare Partners Program)</p> |
|--|---|--|

20. DATE OF REQUEST / CIRCUMSTANCE
(MM/DD/CCYY):

□□/□□/□□□□

21. DATE OF CRG ASSESSMENT
(MM/DD/CCYY):

□□/□□/□□□□

22. CONSUMER INFORMATION INDICATOR:

Indicate the availability of consumer information for completing the CRG form.

☐ MINIMAL ☐ ADEQUATE ☐ SUBSTANTIAL

23. CONSUMER'S CURRENT GAF:

at the time of assessment
(This item must be completed)

□□□

24. CONSUMER'S HIGHEST GAF:

within last one year
(Not required if there is no previous GAF history)

□□□

25. CONSUMER'S LOWEST GAF:

within last one year
(Not required if there is no previous GAF history)

□□□

NOTES: _____

26. PROGRAM CODE:
100% STATE SUPPORTED ☐
JUDICIAL ☐

(Check one)
UNINSURABLE ☐ **TENNCARE**
ELIGIBLE ☐

27. RATER'S TENNCARE PROVIDER ID NUMBER:

□□□□□□□□□□□□□□

RATER'S PRINTED NAME: _____

THE TENNESSEE TARGET POPULATION GROUP (TPG) FORM FOR CHILDREN & ADOLESCENTS UNDER AGE 18

IDENTIFYING INFORMATION

1. CHECK BOX THAT APPLIES: TPG ASSESSMENT - INITIAL <input type="checkbox"/> TPG ASSESSMENT - CORRECTION <input type="checkbox"/> TPG ASSESSMENT - UPDATE <input type="checkbox"/>		
2. BHO ID NUMBER (IF KNOWN) <input type="text"/> <input type="text"/> <input type="text"/>	3. CONSUMER'S SSN: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
4. CONSUMER'S FIRST NAME: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	5. CONSUMERS MIDDLE INITIAL: <input type="text"/>	
6. CONSUMER'S LAST NAME: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
7. CONSUMER'S DOB: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
8. PRINCIPAL DIAGNOSIS: <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	9. DUAL PRINCIPAL / SECONDARY DIAGNOSIS: <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	
10. CONSUMER'S CURRENT GAF: <i>at the time of assessment</i> <i>(This item must be completed)</i> <div style="text-align: center;"><input type="text"/> <input type="text"/> <input type="text"/></div>	11. CONSUMER'S HIGHEST GAF <i>within past one year:</i> <i>(Leave blank if there is no previous GAF history)</i> <div style="text-align: center;"><input type="text"/> <input type="text"/> <input type="text"/></div>	12. CONSUMER'S LOWEST GAF <i>within past one year:</i> <i>(Leave blank if there is no previous GAF history)</i> <div style="text-align: center;"><input type="text"/> <input type="text"/> <input type="text"/></div>
13. SEVERITY OF IMPAIRMENT: Referring to the CONSUMER'S CURRENT GAF (question #10), and the CONSUMER'S LOWEST GAF (question #12) above, is either GAF score lower than 51? (Check "YES" or "NO") <div style="text-align: right;">YES <input type="checkbox"/> NO <input type="checkbox"/></div>		
14. CHILDREN WITH A SERIOUS EMOTIONAL DISTURBANCE (SED)	Referring to the principal diagnosis or the dual principal / secondary diagnosis (question #8) and the two GAF scores previously referenced (questions #10 or #12), is the principal diagnosis or dual principal / secondary diagnosis a current valid DSM-IV-TR diagnosis (excluding: <i>substance use disorders</i> (DSM-IV-TR ranges: 291.00 - 292.90, 303.00 - 305.90), <i>developmental disorders</i> (DSM-IV-TR ranges: 299.00 - 299.80, 315.00 - 319.00), or <i>V-codes</i> (DSM-IV-TR range: V15.81 - V71.09) and is either GAF score less than 51? (Check "YES" or "NO") <div style="text-align: right;">YES <input type="checkbox"/> NO <input type="checkbox"/></div>	
15. ENVIRONMENT ISSUES:	Has the child experienced residential disruption, such as multiple family separations, extended periods of homelessness, failed adoption, or out-of-home placement due to emotional disturbance, or is developmentally delayed due to a poor environment? (Check "YES" or "NO") <div style="text-align: right;">YES <input type="checkbox"/> NO <input type="checkbox"/></div>	
16. FAMILY ISSUES:	Do the child's parents, or persons responsible for care, have predisposing factors, such as severe and/or persistent mental illness, serious family dysfunction, a history of chronic substance abuse (drug or alcohol), or a history of persistent and severe physical illness or disability which creates significant hardship on the family system, that could result in their inability to make provisions for the ongoing physical, social, or emotional needs of their children? (Check "YES" or "NO") <div style="text-align: right;">YES <input type="checkbox"/> NO <input type="checkbox"/></div>	
17. TRAUMA ISSUES:	Has the child experienced a single or multiple physical or psychological traumatic events, such as loss of a parent or being a victim or witness of serious crime or domestic violence? (Check "YES" or "NO") <div style="text-align: right;">YES <input type="checkbox"/> NO <input type="checkbox"/></div>	
18. SOCIAL SKILLS ISSUES:	Does the child exhibit behavior or maturity that is significantly different from most children their age, and which is not the result of developmental disabilities or mental retardation? (Check "YES" or "NO") <div style="text-align: right;">YES <input type="checkbox"/> NO <input type="checkbox"/></div>	
19. ABUSE / NEGLECT ISSUES:	Has the consumer experienced physical, emotional or sexual abuse or neglect? (Check "YES" or "NO") <div style="text-align: right;">YES <input type="checkbox"/> NO <input type="checkbox"/></div>	
20. CHILDREN AT RISK OF SED: Referring to the environment issues (question #15), family issues (question #16), trauma issues (question #17), social skills issues (question #18) and the abuse / neglect issues (question #19), is there a "YES" response to at least one of the questions? (Check "YES" or "NO") <div style="text-align: right;">YES <input type="checkbox"/> NO <input type="checkbox"/></div>		

21. DETERMINATION OF CONSUMER GROUP: The description of each consumer group is given below, based on the answers to the preceding questions.		
Check the box that represents this person's group.		
<div style="text-align: center; margin-bottom: 10px;"> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div> <p>GROUP 2 - Persons who have a SED which has resulted in severe functional impairment. Persons whose principal diagnosis <u>or</u> dual-principal/secondary diagnosis is a current, valid DSM-IV-TR psychiatric diagnosis and are severely impaired ("YES" on question #14).</p>	<div style="text-align: center; margin-bottom: 10px;"> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div> <p>GROUP 3 - Persons who are at risk of a SED. Persons who do not have a current, valid DSM-IV-TR psychiatric diagnosis and / or are not severely impaired ("NO" on question #14) and are at risk of SED ("YES" on question #20).</p>	<div style="text-align: center; margin-bottom: 10px;"> <input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/> </div> <p>GROUP 4 - Persons who do not meet the criteria of TPGs 2 or 3. Persons who do not have a current, valid DSM-IV-TR psychiatric diagnosis and / or are not severely impaired ("NO" on question #14) and are not at risk of a SED ("NO" on question #20).</p>
22. REASON FOR ASSESSMENT (Check One)		
01 <input type="checkbox"/> Consumer requested TPG assessment 03 <input type="checkbox"/> Mental health care provider requested assessment 05 <input type="checkbox"/> TDMHDD requested TPG assessment 07 <input type="checkbox"/> MCO requested TPG assessment 09 <input type="checkbox"/> Consumer is referred for a mental health service in the Enhanced Benefits Package (For currently enrolled participants in the TennCare Partners Program) 11 <input type="checkbox"/> Consumer is admitted to an inpatient psychiatric facility / unit (For currently enrolled participants in the TennCare Partners Program) 13 <input type="checkbox"/> Other	02 <input type="checkbox"/> Family member requested TPG assessment for the consumer 04 <input type="checkbox"/> Primary health care provider requested TPG assessment 06 <input type="checkbox"/> BHO requested TPG assessment 08 <input type="checkbox"/> One year reassessment is due 10 <input type="checkbox"/> Consumer used 40 outpatient mental health benefits in a calendar year (For currently enrolled participants in the TennCare Partners Program) 12 <input type="checkbox"/> Consumer has been admitted to an RMHI and is potentially eligible for Federal and/or State supported benefits (For persons not yet enrolled in the TennCare Partners Program) 14 <input type="checkbox"/> Intake	
23. DATE OF REQUEST / CIRCUMSTANCE (MM/DD/CCYY): <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div>	24. DATE OF TPG ASSESSMENT (MM/DD/CCYY): <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div>	25. CONSUMER INFORMATION INDICATOR: Indicate the availability of consumer information for completing the TPG form. <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div><input type="checkbox"/> MINIMAL</div> <div><input type="checkbox"/> ADEQUATE</div> <div><input type="checkbox"/> SUBSTANTIAL</div> </div>
26. PROGRAM CODE : (Check One)		27. RATER'S TENNCARE PROVIDER ID NUMBER:
100% STATE SUPPORTED <input type="checkbox"/> JUDICIAL <input type="checkbox"/> UNINSURABLE <input type="checkbox"/> TENNCARE ELIGIBLE <input type="checkbox"/>		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div>
RATER'S PRINTED NAME: _____		

TENNCARE PARTNERS PROGRAM ELIGIBILITY ENROLLMENT REQUEST

Patient Name: _____
(Please Print Clearly) First Name MI Last Name

Address: _____ Race: _____

City: _____ TN _____ Sex: _____
Zip Code

SSN: _____ - - - - - / - - - - - / - - - - - County Code: _____
Social Security Number Date of Birth

Service Recipient Signature: _____

CRG / TPG Assessment is _____ . Date of latest Assessment is ____ / ____ / ____.

Section I: State Only Enrollment

Date of Admission to Service: ____ / ____ / ____

- **Anticipated referral at discharge to:**
_____ **CMHA for outpatient services.**

The service recipient identified above qualifies for the TennCare Partners Program as a "State Only".

I certify that the service recipient meets the following criteria:

- The service recipient has a current CRG assessment of CRG1, CRG2, CRG3, OR A TPG2.
- The service recipient's monthly income is \$ _____ and does not exceed the Federal Poverty Guidelines below:

<u>Number in Family</u>	<u>Monthly Income</u>	<u>Number in Family</u>	<u>Monthly Income</u>
1	798	6	2156
2	1069	7	2428
3	1341	8	2699
4	1613	9	2971
5	1884	10	3243

Please **circle number in household**. For each family member over 10, add \$272 per month.

- The service recipient has made application for TennCare or has made application for TennCare and has been denied.
- The following documents must be attached in support:
- Copy of original TennCare application, if available
- Copy of letter, or other TennCare confirmation of denial of application for TennCare benefits, if available
- Copy of CRG/TPG Assessment
- Certificate of Diagnosis signed by a licensed mental health professional
- Verification of U.S. citizenship, Tennessee residence, and income

Section II: Judicial Enrollment

Date of Admission to Service: ____ / ____ / ____

The individual identified above qualifies for the TennCare Partners Program under the following provisions for a Judicial admission:

The individual was admitted at the direction of a court. Check appropriate action and provide the requested documentation and/or information.

_____ (TCA 33-6-PART 4) Involuntary Commitment.

Attach two (2) Certificates of Need.

_____ (TCA 33-6-PART 5) Judicial Commitment. **Attach copy of the court order.**

_____ (TCA 33-6-PART 6) Mandatory Outpatient Treatment.

Attach copy of the court order.

_____ (TCA 33-7-303(b) Mandatory Outpatient Treatment.

Attach copy of the court order.

Section III:

PROVIDER Name:

Signature of
CHIEF EXECUTIVE OFFICER

Date

Mail to: Tennessee Department of Mental Health and Developmental Disabilities
Office of Managed Care, Eligibility Unit
5TH Floor, Cordell Hull Building
425 5th Avenue North
Nashville, TN 37243

MH-5248

Revised: 10/27/2005



Certificate of Diagnosis

Patient Name:		
First Name	MI	Last Name
Social Security Number: - - Date of Birth: / /		

Agency Contact Information

Facility Name: _____

Address: _____
Street Address City State Zip

Office Phone Number: _____ Fax: _____

I certify that the above-named patient has been diagnosed with the following mental health or emotional conditions:

I understand that this information will be used to determine this patient's medical eligibility for State Only or TennCare Standard. I understand any intentional act on my part to provide false information that will potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the State's TennCare program and Title XIX of the Social Security Act.

Date: ____ / ____ / ____ Tennessee License Number: _____

Professional Designation: _____

Licensed Mental Health Professional Signature: _____

MH-5250

(RMHI)

Revised: 07/30/04

**JCCO ATTESTATION
FOR
STATE-ONLY
ENROLLMENT**

I, _____, certify that every effort was made to

SIGNATURE OF CFO

contact and secure the signatures of other TDMHDD authorized parties for this State-Only Enrollment Request for this minor admitted to our facility under JCCO. These efforts having failed, I have signed the request as the signatory of last resort.



STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
OFFICE OF MANAGED CARE, ELIGIBILITY UNIT
425 5TH Avenue North
5th Floor, Cordell Hull Building
Nashville, Tennessee 37243

CONSUMER NAME: _____

SOCIAL SECURITY NUMBER : _____

DATE OF BIRTH: _____

INCOME STATEMENT

I, _____, am not currently employed.
(PLEASE PRINT CONSUMER NAME)

I do not have any income at the present time.

Consumer Signature

Date

Homeless Declaration Statement
Proof of Residence

If consumer is Homeless or living in a Shelter / Mission, please indicate this by completing the bottom portion of this form. To the Counselor or CMHA staff person assisting this consumer, please have the consumer sign where indicated and please counter – sign where indicated.

Date: ____ / ____ / ____ Consumer Signature: _____

Counselor / CMHA (RMHI) staff Signature: _____

Reference Info: 1 A
SS#:

Submitted: CHS
STATUS:
S/OBD:

***Office of Managed Care
State-Only Eligibility Review Unit***

<DATE>

TO: <MENTAL HEALTH PROVIDER>

FROM: Pat Manners, Office of Managed Care, State-Only Eligibility Review Unit
State-Only Coverage for Mental Health Services

RE: Review of State-Only Eligibility: Consumer's Name
 Street Address
 City Zip Code

Please provide correct mailing address if different from the one given above

State-Only Eligibility procedures **require** 3-month reviews of eligibility criteria for each consumer receiving State-Only benefits *for mental health services*. In order for the consumer to continue receiving State-Only coverage please provide the following information then return to the Office of Managed Care, Eligibility Review Unit (address on page 2).

DO NOT DISCARD. If you have no information related to this consumer, make a notation to that effect and return to the Office of Managed Care – Eligibility Review Unit (address on page 2).

1. YES, this consumer is currently receiving mental health services through this facility / agency. The date of consumer's last appointment was _____.

Attach the following:

- A. A copy of the **most recent** **CRG or TPG** (**MUST BE WITHIN PAST 12 MONTHS or updated if diagnosis has changed**), per State-Only procedures.
- B. current **Certificate of Diagnosis** signed by a licensed mental health professional
- C. Attach VERIFICATION of HOUSEHOLD **monthly income** which is \$ _____ ;
of people in the household: _____
- D. Attach VERIFICATION of citizenship, or copy of current Visa, greencard.
- E. Attach VERIFICATION of residency in the state of Tennessee.
- F. If consumer has a dual diagnosis, attach State Only Proof of Attendance for AA and/or NA Meetings (minimum of 1 meeting per week for AA and/or NA. If consumer has alcohol **and** drug issues, meetings at both AA and NA should be reflected.)

2. ____ No, consumer was **referred to another facility/agency**. **Provide name, mailing address including zip code** of facility/agency to which the consumer was referred, **sign on page 2 as required**, then return this form to address given on page 2.

Agency

Street Address

City & Zip Code

____ No, consumer was discharged the month of _____, year _____.

____ No, consumer refused services, did not return following intake or has not returned for services.

____ No, consumer has moved out of the county, out of state, out of the country.
(Circle one)

____ No, consumer is incarcerated.

____ No, consumer has access to mental health services through the Veteran's Administration or has access to private insurance.

(Application is incomplete without the above requested information & SHALL RESULT IN TERMINATION OF COVERAGE)

>>> Preparer's Signature – REQUIRED: _____

***In order to prevent termination of consumer's State-Only coverage,
Return no later than <DATE>, via fax to (615) 253 – 3187***

OR by **mail** to:

Tennessee Department of Mental Health and Development Disabilities

OMC - ELIGIBILITY REVIEW UNIT

5th Floor – Cordell Hull Building

425 Fifth Avenue North

Nashville, TN 37243

ATTN: Pat Manners

If you have any questions, please contact me by phone (615) 532-8688, or e-mail: HYPERLINK mail to:
Patricia.Manners@state.tn.us Thank you for your cooperation.

FACILITATOR

[illegible]



STATE ONLY APPEAL REQUEST FORM

NAME OF PERSON ASKING FOR APPEAL (PLEASE PRINT)	DATE ____/____/____ (Month) (Day) (Year)
ADDRESS(P.O. Box, Rural Route, Apt. No., Street No., Name, etc) _____ _____ _____ City State Zip	SOCIAL SECURITY NUMBER _____ TELEPHONE NUMBER: (____) _____ - _____

Reason for Appeal

Please check the box that best matches the decision you want to appeal and **provide documentation** to support your reason for appeal:

- ☐ My income is NOT above the limit. My income is \$_____ per month for a ____member household.
- ☐ I do have a current CRG rating of 1,2, or 3.
- ☐ I do have a current TPG rating of 2.
- ☐ I am an U.S. citizen.
- ☐ I am a legal resident Alien.
- ☐ I am a resident of Tennessee.
- ☐ I am NOT an inmate.
- ☐ I do NOT have access to private health insurance
- ☐ I do NOT have Medicare coverage .
- ☐ I am NOT currently receiving or am NOT eligible to receive TennCare benefits.
- ☐ I AM currently receiving mental health services at _____
The date of my last appointment was _____; my next appointment is scheduled for _____.
Attached is a copy of my current CRG provided by the mental health center.

MAIL YOUR COMPLETED FORM WITH NECESSARY DOCUMENTATION TO:

TDMHDD
OFFICE OF CONSUMER AFFAIRS,
ATTN: ELIGIBILITY APPEALS
P.O. BOX 332548
NASHVILLE, TN 37203



TERMINATION OF STATE-ONLY COVERAGE APPEAL FORM

NAME OF PERSON ASKING FOR APPEAL (PLEASE PRINT)	DATE ____/____/____ (Month) (Day) (Year)
ADDRESS(P.O. Box, Rural Route, Apt. No., Street No., Name, etc)	SOCIAL SECURITY NUMBER
_____ _____ City State Zip	TELEPHONE NUMBER: (____) _____ - _____

Having received a notice of termination of State-Only coverage for mental health services, I wish to file an appeal. Enclosed is the required documentation including:

- **this completed form,**
- **a current CRG,**
- **a recent certificate of diagnosis**
- **an updated State-Only enrollment request form**

made available by my mental health provider to support my reason for appeal. I understand this ***appeal CANNOT be processed without the required documentation listed above. I also understand that lack of documentation will result in termination of State-Only coverage.***

I AM currently receiving mental health services at :

The date of my last appointment was _____;

My next appointment is _____.

Consumer's signature: _____

MAIL THIS COMPLETED FORM WITH ALL REQUIRED DOCUMENTATION AS LISTED ABOVE TO:

TDMHDD
Office of Consumer Affairs
3rd Floor, Cordell Hull Bldg
P. O. Box 332548
Nashville, TN 37203
Attn: State-Only Eligibility Appeals

Appendix III: Policy and Enrollment Procedures for State Only

POLICY AND ENROLLMENT PROCEDURES FOR STATE-ONLY

CRITERIA

Individuals qualify for the State-Only category if :

- A. They have been determined ineligible for any other category of TennCare, or have a pending TennCare application; and
- B. They do not have access to private health insurance, or the private health insurance lacks mental health coverage, or all mental health benefits under private health insurance have been exhausted; and
- C. They do not have access to Medicare coverage; and
- D. They are not actively receiving benefits through the Veteran's Administration.
- E. They are a U.S. Citizen or a legal resident Alien, **and** a resident of Tennessee;
- F. They have been identified as SPMI/SED (CRG = 1,2, or 3; TPG = 2); and
- G. The family income is no greater than 100% of the Federal Poverty level; and
- H. They must not be an inmate.

NOTE: Individuals who were terminated from TennCare Standard coverage as a part of TennCare Reform **and** with access to CTR (safety net) services are **not** eligible for State Only coverage.

COVERED SERVICES

Covered services for service recipients **21 years of age and older** enrolled as State Only include:

- 1. Psychiatric inpatient hospital services (including physician services);
- 2. Outpatient mental health services (including physician services);
- 3. Inpatient/residential & outpatient substance abuse services (limited to 10 days detoxification and \$30,000 in medically necessary lifetime benefits);
- 4. 24-Hour psychiatric residential treatment;
- 5. Mental health case management;
- 6. Non-emergency transportation;
- 7. Emergency air & ground ambulance services;
- 8. Psychiatric rehabilitation services;
- 9. Psychiatric medications (limited to 5 prescriptions a month with only 2 brand names); and
- 10. Lab related to medication management.

Covered services for service recipients **under 21 years of age** enrolled as State Only include:

1. Psychiatric inpatient hospital services (including physician services);
2. Outpatient mental health services (including physician services);
3. Inpatient/residential and outpatient substance abuse services;
4. 24-Hour psychiatric residential treatment;
5. Mental health case management;
6. Non-emergency transportation;
7. Emergency air & ground ambulance services;
8. Psychiatric medication management;
9. Psychiatric medications; and
10. Lab related to medication management.

EFFECTIVE DATES

The effective date of enrollment depends upon the timely receipt of an appropriately completed applications from providers. If a completed application is received within thirty (30) calendar days from the initial service date, the initial service date will be the effective date of enrollment. If a completed application is received more than thirty (30) calendar days from the initial date of service, the effective date of enrollment will be the date the completed application is received by TDMHDD's Eligibility Unit. **Important Note:** If an incomplete application is received within thirty (30) calendar days from initial date of service and it is not rectified within this time period, the effective date of enrollment will be the date the completed application is received by the Eligibility Unit.

Effective termination date is the date that the person no longer meets the criteria for participation in this category or the date the person becomes eligible for TennCare (Medicaid), whichever comes first.

STATE-ONLY ENROLLMENT REQUEST PROCESS:

- A. Provider will complete the State-Only Enrollment Request providing demographic information.
- B. Provider will submit the following documents to TDMHDD Office of Managed Care, Eligibility Unit:
 1. Completed State-Only Enrollment Request with original signature of the provider's Chief Executive Officer or the designee of the CEO and original signature of the applicant. In the case of a minor applicant, a responsible adult should sign the State Only Enrollment Request for the minor. The following is a prioritized list of TDMHDD approved individuals who can sign for a minor applicant.

- a. Parents.
 - b. Legal or Custodial Guardian.
 - c. Grandparents.
 - d. Adult siblings.
 - e. Case Manager.
 - f. DCS Representative.
 - g. Inpatient Provider's Chief Financial Officer (for JCCO cases only).
- Regarding instances of JCCO minor applicants, the CFO is to be the signatory of last resort and should only sign after all efforts to secure the signatures of the other authorized individuals have failed.
 - Additionally, the form entitled "JCCO Attestation for State Only Enrollment" should be completed and signed by the CFO.
2. A completed State Only Certificate of Diagnosis;
 3. Copy of the original TennCare (DHS) Application; or copy of DHS Notice of Disposition confirming that Service Recipient applied for TennCare Medicaid and was denied or that application is still in pending status;
 4. Copy of letter or other confirmation from TennCare indicating denial of eligibility, if available;
 5. A current and qualifying CRG/TPG Assessment;
 - a. CRG must be completed within the past 12 months and have an assessment code of 1, 2 or 3
 - b. TPG must be completed within the past 12 months and have an assessment code of 2.
6. Verification of identity;
 7. Verification of U.S. citizenship or alien status;
 - a. Verification of U.S. citizenship or Legal resident Alien status will only be required when the consumer's statements regarding their citizenship or alien status appear to be contradictory. (i.e. Consumer presents an apparently counterfeit Social Security card. Consumer claims U.S. citizenship, but they were born overseas.)
 - b. For U.S. citizenship, the permissible forms of documentation are birth certificates, religious records (i.e. records of births and deaths kept in a family Bible or a baptismal record), voter registration cards, certificates of citizenship or naturalization provided by Bureau of Citizenship and Immigration Service (BCIS), or U.S. passports.
 - c. For verification of Legal Resident Alien status the permissible forms of documentation are "green" card, visa, or Form I-688 (Temporary Resident card).
 - d. If needed, verification of U.S. citizenship will only need to be supplied once. After the documentation is on file, it will not need to be sent a subsequent time. For Legal Resident Aliens this verification will be needed once yearly.
8. Verification of Tennessee residence;

- a. Permissible forms of verification are rent receipt in the consumer's name, utility bill in the consumer's name, voter registration card, Tennessee driver's license, Tennessee state I.D. card, or in the absence of the above, a signed and dated statement from a collateral contact, a person familiar with the applicant's circumstances (i.e. family member, friend, case manager, etc.)
- b. If a service recipient claims to be homeless, then a completed copy of the State Only Income and Homeless Declaration Form (see page 34) should be included.

9. Verification of income.

- a. Earned Income: Earned income is income realized from work. If a service recipient is employed, their income would need to be verified by one (1) month's pay stubs or by a written, signed, and dated statement from the employer, stating the average number of hours worked each month and the hourly wage. A copy of the first page of the previous year's tax return, showing the Total Income for the household, is also acceptable verification. If the service recipient is paid on a cash basis, then the written, signed, and dated statement from the employer will suffice.
- b. Unearned Income: Unearned income is defined as income not directly realized from work (i.e. Social Security income, unemployment benefits, Family First (TANF) grants, or cash gifts from family and/or friends. In the case of a Social Security check, unemployment check, or similar benefit check, permissible verifications include a copy of the check itself; a copy of a bank statement, if benefit is direct deposited; a copy of the benefit letter or change of benefit letter; or a print out from the issuing agency (i.e. a print out from SSA in the case of Social Security or DHS in the case of a Family First grant). In the case of cash gifts, a written, signed and dated statement from the giver will suffice for documentation.
- c. If a service recipient reports that he or she lacks income of any type, then a completed copy of the State Only Income and Homeless Declaration Form (see page 34) should be included.
- d. Guidelines on whose income to consider for State Only eligibility are outlined below.
 - Any income realized by the State Only applicant himself or herself is counted.
 - If the State Only applicant is married, then the spouse's income is considered in determining the applicant's State Only eligibility in addition to point 1 above.
 - Any income of a parent or a legal/custodial guardian is counted in determining the eligibility of a minor child in addition to point 1 above.
 - In the case of adult children living with their parents, the parents' income is not countable in determining the adult child's State Only eligibility.
 - In the case of parent(s) living with their adult children, the adult child's income is not counted in determining the parent(s) State Only eligibility.

- In the case of adult siblings living together, and income of one of the siblings does not count against the State Only eligibility of the other sibling.
 - In the case of non-related adults living together (i.e. roommates), the income of one roommate does not count against the State Only eligibility of the other roommate.
- C. The Provider may fax completed State-Only requests to TDMHDD. Completed State-Only requests should be faxed to (615) 253-3187. Alternately, the completed State-Only request can be mailed to TDMHDD. The appropriate mailing address is listed at the bottom of the State-Only Enrollment Request form. **If the fax option is utilized, it is not necessary to follow-up with an original copy.** Regardless of the submission option chosen, the completed State Only Enrollment packet should be sent to TDMHDD within fourteen (14) calendar days of the individual's date of admission to service, but not more than thirty (30) calendar days from the date of admission to service.
- D. TDMHDD Office of Managed Care will perform a check to verify that the individual is not currently enrolled in TennCare.
- E. TDMHDD Office of Managed Care will review the State-Only Enrollment Request and supporting documentation to determine that criteria for State-Only category are met and that information is complete.
1. If the enrollment packet is incomplete:
 - a. The enrollment packet will be returned to the provider with an explanation of the missing information. **CORRECTED ENROLLMENT PACKET MUST BE RETURNED TO TDMHDD WITHIN FIVE (5) BUSINESS DAYS FROM THE DATE THE PROVIDER RECEIVES THE RETURNED PACKET.**
 - b. Provider furnishes the missing information and returns documentation to TDMHDD within five (5) business days.
 - c. If the missing information is not or cannot be corrected, Provider returns packet, with explanation that information cannot be provided, within the five (5) business days.
 - d. If the corrected enrollment packet is not returned to TDMHDD within the specified timeframe, the State-Only Enrollment Request will be denied by TDMHDD, a denial letter with appeal form will be issued to the applicant, explaining the applicant's due process rights.
 2. If the enrollment packet is complete, and
 - a. The applicant is eligible; TDMHDD will notify the TennCare Bureau. The TennCare Bureau will then send the applicant an approval letter, or
 - b. The applicant is ineligible because he/she does not meet the criteria; TDMHDD will issue a denial letter with appeal form to the applicant, explaining the applicant's due process rights

- F. TDMHDD will review State-Only eligibility at least every three (3) months to determine if the individual remains eligible.
1. At the initial three-month review, a State-Only Eligibility Review Letter will be sent to the Provider. This letter will address and capture updated data on all State-Only eligibility criteria, including the individual's most recent date of service. The State-Only Eligibility Review letter must be completed, signed by its preparer, and returned to the Eligibility Unit by the date specified in the letter, or the individual may lose their State-Only coverage.
 2. If the individual remains eligible for State-Only coverage for an additional three months, another State-Only Eligibility Review Letter will be issued to the Provider. At the point, that the State-Only program will have covered an individual for a full 12 months, an updated State-Only Enrollment Request form, Certificate of Diagnosis, and CRG/TPG assessment will be required to determine continued eligibility. Additionally, at this point the Provider should again instruct and assist the individual in applying for full TennCare coverage.
 3. If the individual continues to meet the State-Only eligibility criteria, notation is made in the eligibility record and coverage continues.
 4. Coverage under the State-Only program will be terminated if:
 - a. The individual no longer meets the criteria above or is found to have falsified information provided to TDMHDD and approval was based on this false information; or
 - b. The individual voluntarily requests disenrollment; or
 - c. The individual dies.
 5. If the determination is made that the individual no longer meets the criteria for State-Only coverage, an Initial Termination Notice and State Only Appeal form will be issued to the individual, explaining the reason for their termination and their due process rights. The individual will be given twenty (20) calendar days to respond to the Initial Termination Notice. If at the end of the twenty (20) calendar days, the individual has not responded to the initial notice, a computer closure document will be submitted to terminate the State-Only coverage and a Final Termination Notice will be issued to the individual.

Appendix IV: Policy and Enrollment Procedures for Judicial Admissions

ENROLLMENT PROCEDURES FOR JUDICIAL ADMISSIONS

CRITERIA

Applicants qualify for Judicial coverage if:

- A. They are not eligible for TennCare coverage; and
- B. They do not have access to private health insurance; and
- C. They do not have Medicare coverage, or Medicare hospital and/or doctor's days have been exhausted; and
- D. They are not actively receiving benefits through the Veteran's Administration; and
- E. They have been **involuntarily** committed to a psychiatric hospital **or** directed to receive Mandatory Outpatient Treatment (MOT) services from an outpatient provider of behavioral health services; and
- F. They have been identified as being non-SPMI/SED based upon the current CRG/TPG assessment (i.e. CRG = 4 or 5; TPG = 3 or 4); or
- G. They have been determined to be SPMI/SED, but they fail to meet other State-Only enrollment criteria (i.e. income exceeds applicable FPL). They otherwise meet the Judicial enrollment criteria stated in points "A" through "D".

COVERED SERVICES

Covered services are limited to only involuntary psychiatric hospitalizations and court ordered mandatory outpatient treatment services covered by the TennCare Partners Program.

EFFECTIVE DATES

The effective start date of benefits is whichever of the following comes first:

- A. The date of the determination for involuntary hospitalization, or
- B. The date of the admission to an inpatient facility as the result of a commitment order, or
- C. The date of discharge from the inpatient facility to mandatory outpatient treatment.

The effective termination date is:

- A. The date the court-ordered service ended, or
- B. The date on which the individual becomes eligible for the TennCare Partner's Program through another eligibility category (i.e. approval for TennCare-Medicaid).

JUDICIAL ADMISSIONS ENROLLMENT REQUEST PROCESS

- A. Provider will complete Sections II and III of the TennCare Partners Program Eligibility Enrollment Request providing demographic information.
- B. Provider will submit the following documents to TDMHDD Office of Managed Care:
 - 1. Completed TennCare Partners Program Eligibility Enrollment Request with original signature of the provider's Chief Executive Officer or their designee;
 - 2. Copy of current CRG/TPG assessment.
 - 3. Copy of the TennCare-Medicaid (DHS) application (for hospital admissions); and
 - 4. A copy of the court order for treatment or two Certificates of Need for involuntary hospitalizations.
- C. TDMHDD Office of Managed Care will perform a check to verify that the individual is not currently enrolled in TennCare.
- D. TDMHDD Office of Managed Care will review the TennCare Partners Program Eligibility Enrollment Request packet to determine that criteria for Judicial coverage is met and that the information is complete.
 - 1. If the information is incomplete, the enrollment packet will be returned to provider with an explanation of missing information. **CORRECTED INFORMATION PACKET MUST BE RETURNED TO TDMHDD WITHIN FIVE (5) BUSINESS DAYS FROM THE DATE THE RETURNED PACKET IS RECEIVED BY THE PROVIDER.**
 - 2. When TDMHDD determines that the information is complete, an approval for Judicial coverage will be electronically transmitted to the TennCare Bureau.
- E. The TennCare Bureau will notify the BHO of the individual's eligibility.
- F. TDMHDD reviews eligibility records monthly to determine if the court order or commitment is still active and takes the following action:
 - 1. If the court order or commitment has ended, information is sent to the TennCare Bureau to terminate the enrollment of the individual as a Judicial. The TennCare Bureau will then notify the BHO that the individual's enrollment as a Judicial has ended.
 - 2. If the court order or commitment has not ended, eligibility will continue and eligibility records will be reviewed at the next monthly interval.

Appendix V:
Policy and Procedures
for Appeals
of
State Only Enrollment

**POLICY AND PROCEDURES
FOR
APPEALS OF STATE-ONLY REQUESTS**

STATE-ONLY ENROLLMENT APPEAL PROCEDURES

All applicants for State-Only eligibility status shall have a right to appeal any decision that would deny enrollment into this category. Per the recommendation of the Attorney General's Office this right is NOT part of the Grier or Rosen lawsuits since this category has no entailment associated. This is due to the funding for this category being 100% state dollars, and that these enrollees are not otherwise TennCare eligible.

These appeals will be filed with the TDMHD Office of Consumer Affairs who shall provide a 3-step review process. The first step shall be that the Eligibility Unit of the Office of Managed Care will be asked to reconsider its initial denial. The second step shall be a review by the Office of Consumer Affairs who shall be authorized to overturn the denial for cause. The third step shall be a review by a TDMHDD hearing officer whose decision shall be final.

Currently letters of denial and notice of appeal rights will be issued by TDMHDD. All notices and appeal time frames will be tracked by TDMHDD and only final decision to load a new eligibility segment or terminate a current segment will be communicated to TennCare. For decisions to terminate eligibility following a required 3-month review will be communicated to TennCare who will load the termination into the TCMIS. This termination will then take place after 30 days.

STATE-ONLY ENROLLMENT APPEAL PROCEDURES

- A. Applicant receives notification from TDMHDD that his/her State-Only enrollment request has been denied, because he/she failed to meet (continue to meet in the case of 3 month review) the criteria for eligibility as defined on the State-Only Request Form or failed to file a complete State-Only Enrollment Request within the specified timeframes.
- B. Applicant files a request for appeal to the DMHDD Office of Consumer Affairs (OCA) within twenty (20) days of the date in the letter. The appeal can be requested by phone, letter or by returning the Appeal Request Form attached to the denial notification.
- C. When the appeal is received, the OCA will log the appeal and send to the Eligibility Unit of the Office of Managed Care for reconsideration.
 - 1. If the appeal is based on the CRG or TPG rating, the eligibility unit will forward the appeal the Assessment Unit for review.
 - 2. If the appeal is based on incorrect or incomplete information, or other reason, the Eligibility Unit will re-evaluate the State-Only Enrollment Request.
 - 3. If the outcome of this review is that the applicant is deemed to be eligible, the Eligibility Unit will notify the OCA that the denial has been reversed and forward the State-Only approval to the TennCare Bureau.
 - 4. If the outcome of this review is that the applicant is deemed to not be eligible, the Eligibility Unit will notify OCA that the denial has been upheld.

- D. The OCA will review all Eligibility Unit decisions that result in the denial being upheld. OCA will contact enrollee to obtain any information needed to complete the review process. OCA shall have the authority to either overturn or uphold the denial by the Eligibility Unit
- E. The OCA will notify the applicant of it's, and or the Eligibility Unit's, decision and the effect on the applicant's enrollment.
 - 1. If the denial has been reversed, the applicant will be notified that they are now eligible as State-Only for at least 3 months at which time their status will be reviewed.
 - 2. If the denial has been upheld, the applicant will be notified and advised of his/her right to request a hearing with a TDMHDD hearing officer. The notice will include instructions on how to request a hearing and that the request must be made within ten (10) business days of the receipt of this denial.
- F. The OCA will make arrangements with the hearing officer when notified by the applicant that a hearing is requested. The hearing officer will notify the OCA of their decision and the OCA will notify the applicant and the Eligibility Unit. The decision of the hearing officer is considered final and will be implemented immediately.
- G. All response times shall be calculated from the date of the letter allowing 5 days for mail to reach the appellant and 5 days for mail to return from the appellant to MHDD.